(v) Oncology summary or consultation report;

(5) Reports of radiographic studies, including:

(i) X-rays of the chest;

(ii) Chest tomograms;

(iii) Computer-assisted tomography (CT);

(iv) Magnetic resonance imaging (MRI);

(6) Death certificate, provided that it is signed by a physician at the time of death.

§ 79.36 Proof of non-malignant respiratory disease.

(a) Written medical documentation is required in all cases to prove that the claimant developed a non-malignant respiratory disease. Proof that the claimant developed a non-malignant respiratory disease must be made either by using the procedure outlined in paragraphs (b) or (c) of this section, or submitting the documentation required in paragraph (d) of this section.

(b) *Verification by PHS or NIOSH records.* In all cases the Radiation Exposure Compensation Unit will follow the procedures set forth in § 79.35(b) to establish the claimant's eligibility based on the development of a non-malignant respiratory disease.

(c) *Verification by a federally-supported health-study.* The Unit will follow the procedures set forth in section 79.35(d) to establish the claimant's eligibility based on the development of a non-malignant respiratory disease.

(d) Proof that the claimant contracted a non-malignant respiratory disease may be made by the submission of the following contemporaneous medical records, provided that the specified document contains an explicit statement of diagnosis or such other information or data from which the appropriate authorities designated by the Surgeon General or NIOSH can make a diagnosis to a reasonable degree of medical certainty. For purposes of this section, a statement of diagnosis in any of the Indian Health Service records listed below of ''restrictive lung disease'' will be considered equivalent to a diagnosis of pulmonary fibrosis.

(1) Pulmonary fibrosis or fibrosis of the lung.

(i) If the claimant is deceased, one or more of the following medical records:

(A) Pathology report of tissue biopsy;

(B) Autopsy report;

(C) If x-rays exist, the x-rays *and* interpretive reports of the x-ray(s) by two certified ''B'' readers classifying the existence of fibrosis of Category 1/0 or higher according to the ILO 1980, or subsequent revisions;

(D) If no x-rays exist, an x-ray report;

(E) Physician summary report;

(F) Hospital discharge summary report;

(G) Hospital admitting report;

(H) Death certificate, provided that it is signed by a physician at the time of death.

(ii) If the claimant is alive, (A) One of the following:

(*1*) *Chest x-rays and two ''B'' reader interpretations.* A chest x-ray administered in accordance with standard techniques on full size film at quality 1 or 2, and interpretative reports of the x-ray by two certified ''B'' readers classifying the existence of fibrosis of category 1/0 or higher according to the ILO 1980, or subsequent revisions; or

(*2*) *Pathology reports of tissue biopsies.* A pathology report of a tissue biopsy, but only if performed for medically justified reasons; and

(B) One or more of the following:

(*1*) *Pulmonary function tests.* Pulmonary function tests consisting of three tracings recording the results of the forced expiratory volume in one second (FEV1) and the forced vital capacity (FVC) administered and reported in accordance with the Standardization of Spirometry—1987 Update by the American Thoracic Society, and reflecting values for FEV1 or FVC that are less than or equal to 80% of the predicted value for an individual of the claimant's age, sex, and height, as set forth in the Tables in Appendix A; or

(*2*) *Arterial blood-gas studies.* An arterial blood-gas study administered at rest in a sitting position, or an exercise arterial blood-gas test, reflecting values equal to or less than the values set forth in the Tables in Appendix B of this part.

(2) *Cor pulmonale.* Proof of pulmonary fibrosis as prescribed in paragraph (d)(1) of this section and one or more of the following medical records:

(i) Right heart catheterization;
(ii) Cardiology summary or consultation report;
(iii) Electrocardiogram;
(iv) Echocardiogram;
(v) Physician summary report;
(vi) Hospital discharge report;
(vii) Autopsy report;
(viii) Report of physical examination;
(ix) Death certificate, provided that it is signed by a physician at the time of death.

(3) *Moderate or severe silicosis or pneumoconiosis.* To establish eligibility for compensation for silicosis or pneumoconiosis, a claimant or eligible surviving beneficiary must:

(i) Submit the same documentation as is prescribed in paragraph (d)(1) of this section for proof of pulmonary fibrosis; and

(ii) Submit proof of employment in a uranium mine on an Indian Reservation in accordance with the provisions of §79.33. A claimant or eligible surviving beneficiary must establish that the claimant was employed in a uranium mine on an Indian reservation for a sufficient period of time to meet the exposure criteria set forth in §79.32(c).

(e) The Radiation Exposure Compensation Unit may seek qualified medical review of ''B'' reader interpretations or pathology reports of tissue biopsies submitted by a claimant or eligible surviving beneficiary or obtain additional ''B'' reader interpretations or pathology reports of tissue biopsies at any time to ensure that appropriate weight is given to this evidence and to guarantee uniformity and reliability. This review may include obtaining additional chest x-ray interpretations and additional pathology reports of tissue biopsies.

[Order No. 1580–92, 57 FR 12435, Apr. 10, 1992, as amended by Order No. 2213–99, 64 FR 13691, Mar. 22, 1999]

§79.37 Proof of non-smoker and diagnosis prior to age 45.

(a)(1) In order to prove a history of non-smoking for purposes of §79.32(c)(1), and/or diagnosis of a compensable disease prior to age 45 for purposes of §79.32(c)(2)(i), the claimant or eligible surviving beneficiary must submit all medical records listed in this paragraph (a)(1) from any hospital, medical facility, or health care provider that were created within the period six (6) months before and six (6) months after the date of diagnosis of primary lung cancer or a compensable nonmalignant respiratory disease:

(i) All history and physical examination reports;

(ii) All operative and consultation reports;

(iii) All pathology reports;

(iv) All physician, hospital, and health care facility admission and discharge summaries.

(2) In the event that any of the records in paragraph (a)(1) no longer exist, the claimant or eligible surviving beneficiary must submit a certified statement by the custodian(s) of those records to that effect.

(b) If, after a review of the records listed in paragraph (a) of this section, and/or the information possessed by the PHS, NIOSH, state cancer or tumor registries, state authorities, or the custodian of a federally supported health-related study, the Assistant Director finds that the claimant was a smoker, and/or that the claimant was diagnosed with a compensable disease after age 45, the Unit will notify the claimant or eligible surviving beneficiary and afford that individual the opportunity to submit other written medical documentation in accordance with §79.52(b) to establish that the claimant was a non-smoker and/or was diagnosed with a compensable disease prior to age 45.

(c) The Unit may also require that the claimant or eligible surviving beneficiary provide additional medical records or other contemporaneous records and/or an authorization to release such additional medical and contemporaneous records as may be needed to make a determination regarding the claimant's smoking history and/or age at diagnosis with a compensable disease.

(d) If the custodian(s) of the records listed in paragraph (a) of this section and the records requested in accordance with paragraph (c) of this section certifies that a claimant's records no longer exist, and information possessed by the PHS, NIOSH, state cancer or tumor registries, state authorities, or the custodian of a federally supported